IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
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PHONE 208-334-6626
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May 22, 2008

Cathy Jerrems
First Choice Home Care
9474 West Fairview Avenue
Boise, Idaho 83704

RE: First Choice Home Health, provider #137108

Dear Ms. Jerrems:

This is to advise you of the findings of the Medicare survey at First Choice Home Care which was concluded on May 9, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.

2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.

3. Identify the date each deficiency has been, or will be, corrected.

4. Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by **June 4, 2008**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

PATRICK HENDRICKS
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Co-Supervisor
Non-Long Term Care

PH/mlw

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137108	A. BUILDING _____ B. WING _____	05/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FIRST CHOICE HOME CARE	9474 W FAIRVIEW AVENUE BOISE, ID 83704

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G 000	INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the recertification survey were: Patrick Hendrickson, RN, HFS, Team Leader Sharon Mauzy, RN, HFS Patricia O'Hara, RN, HFS Joanne Rokosky, RN, CMS Acronyms used in this report: BG's= Blood Sugars HHA = Home Health Agency MG = Milligrams MSW = Medical Social Worker POC = Plan of Care RN = Registered Nurse SOC = Start of Care	G 000	RECEIVED JUN 04 2008 FACILITY STANDARDS	
G 144	484.14(g) COORDINATION OF PATIENT SERVICES The clinical record or minutes of case conferences establish that effective interchange, reporting, and coordination of patient care does occur. This STANDARD is not met as evidenced by: Based on observation, clinical record review, review of agency policies, and staff interview it was determined the HHA failed to ensure that patients' clinical records and case conferences for 3 of 16 sample patients (Patients #1, 5 and 6) whose records were reviewed, documented an effective interchange, reporting, and coordination of patient's blood sugar results, medication orders	G 144	The Administrator, Cathy Jerrems reviewed and instructed on three First Choice policies: 1) Care Coordination 2-025.1. 2) Case Conference/Progress Summary 2-027.1. 3) Coordination of Services 2-035.1.with other Providers. Coordination of Services with other Providers would include ALF's. All professional staff at First Choice are now aware of the purpose and importance of coordination for the care and safety of our patients. All staff, including RN, PT, OT, and MSWwill monitor compliance wiht this standard on a quarterly basis and turn results in to the	RN, 5/20/08 SLP

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Cathy Jerrems RN — Administrator — 6/2/08

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 144	Continued From page 1 and pain issues between the HHA and patients' caregivers and/or intra-departmental with-in the HHA. This failure lead to a delay of medical and medication interventions for patients'. Findings include: *Patient #1 was admitted to the HHA's services on 10/30/07, with diagnoses which included diabetes as the primary diagnosis. The patient resided in an Assisted Living Facility. The Assisted Living Facility employed a registered nurse who was responsible for the health management of the patient. The HHA's "CARE COORDINATION" policy, dated January 2004 stated "The clinicians will be responsible for facilitating communications about changes in the patient's status among the assigned personnel... written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visit reports in the patient's clinical records....Organization personnel will communicate changes in a timely manner via telephone, one-to-one meetings, case conferences and home visits. Documentation of all communications will be included in the clinical record on a communication note, case conference summary, or clinical note. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication...Written evidence of care coordination may be found in the plan of care, case conference summary forms, or clinical notes in the patient's clinical record." The agency's policy did not include how the agency was to coordinate care with a patient living in an Assisted Living Facility, with access to skilled	G 144	Administrator for review. Results will be shared with all staff during staff meetings and on an individual basis.	

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G 144	Continued From page 2 nursing and other unlicensed staff involved in the day-to-day care of the patient. The principal diagnosis for the HHA was listed on both certification periods as being related to Diabetes care. The patient's POC's dated 10/30/07 stated that skilled nursing was to instruct the client and the caregiver in the management of the patient's diabetic care. On May 15, 2008 at 11:50 AM, the Program Manager of the American Diabetes Association in Portland, stated that a normal blood glucose level is anywhere between 80 and 140mg/Dl, in the elderly. The patient's record contained a fax dated 11/1/07, to the physician from the HHA's nurse which documented the patient's abnormal blood sugar results are as follows: 11/1/07-AM 173 Eve 195 HS (night-time)275 11/2/07 AM 163 Eve 175 HS 210 11/3/07 AM 171 HS 283 11/4/07 AM 219 Eve 230 HS 185 11/5/07 Eve 276 HS 414 11/6 /07AM 193 Eve 188 HS 326 11/7/07 AM 177 Eve 357 HS 441	G 144		

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G 144	Continued From page 3 11/8/07 AM 145 Eve 237 HS 322 11/9/07 Eve 510 HS 333 11/10/07 Eve 305 HS 184 11/11/07 Eve 260 HS 288 11/12/07 Eve 402 There was no documented evidence in the patient's record that the HHA had communicated the patient's blood glucose variances with the Assisted Living Facility. The HHA case conference notes dated from 11/13/07 to 2/2/08 documented the Assisted Living staff was not present or consulted during the conferences. Only the Skilled Nursing and Physical Therapy groups were in attendance. The patient's POC, dated 12/30/07, did not state how the HHA was going to coordinate the patient's diabetic care with the Assisted Living. The patient's record contained a fax, dated 1/29/08, to the physician from the HHA's nurse which documented the patient's abnormal blood sugar results are as follows: 1/15/08 Eve 360 HS 535 1/16/08 AM 239 Eve 285 HS 309 1/17/08 AM 258 Eve 310 1/18/08 AM 177 Eve 477	G 144		

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G 144	Continued From page 4 HS 438 1/19/08 AM 334 Eve 195 HS 455 1/20/08 AM 234 Eve 333 HS 335 1/21/08 AM 163 Eve 284 HS 393 1/22/08 AM 327 Eve 273 HS 366 1/23/08 AM 152 Eve 181 HS 284 1/24/08 AM 166 Eve 308 HS 450 1/25/08 AM 167 Eve 331 HS 300 1/26/08 AM 277 Eve 403 HS 510 1/27/08 AM 297 HS 247 There was no documented evidence in the patient's record that the HHA had communicated the patient's blood glucose variances with the Assisted Living Facility. The HHA case conference notes documented the Assisted Living staff was not present or consulted during the conferences. A Skilled Nursing Visit Note written on 2/1/08 stated "BG's elevated".	G 144		

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G 144	Continued From page 5 A Skilled Nursing Visit Note written on 2/5/08 stated "BG's since 2/1/08 low 300's except one in the 400's." A Skilled Nursing Visit Note written on 2/12/08 stated that "Insulin changed by MD yesterday." Patient #1 went from 12/27/07 until 2/11/08 without any change in insulin orders to help with her diabetic condition. Durning an interview with the administrator, which occurred at 1:30 PM on 5/8/08, the administrator verified that there was no documentation to support the necessary coordination of services within the organization. The agency failed to ensure the patient's clinical record and case conferences documented that effective interchange, reporting, and coordination of patient care had occurred. * Patient #5 was admitted to the agency on 4/10/09 following hospitalization for an upper respiratory infection, bronchitis, and asthma exacerbation. The home health plan of care for the certification period 4/10/08 - 6/8/08 included skilled nursing and physical therapy. Review of home visit notes by skilled nursing dated 4/10/08, 4/11/08, 4/14/08, 4/16/08, 4/18/08, 4/23/08, 4/25/08, 4/29/08, and 5/6/08 revealed no documentation of communication from the registered nurse to the physical therapist or physical therapy assistant. Review of the care conference book revealed a care conference summary for Patient #5 dated 4/29/08. The note was blank; no other notes for Patient #5 were located in the care conference book. The agency did not have documented evidence	G 144		

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G 144	Continued From page 6 that care had been coordinated among all disciplines involved in Patient #5's care. * Patient #6 was admitted to the agency on 2/13/08, with diagnoses including hemiplegia (paralysis of one side) following a stroke and compounded by post-polio syndrome. The patient was originally certified from 2/13/08 - 4/12/08 and recertified for 4/13/08 - 6/11/08. Home health services were provided by physical therapy, occupational therapy, home health aide, and medical social work. The original comprehensive assessment completed by physical therapy on 2/13/08 indicated that the patient experienced no pain. However, the recertification follow-up assessment dated 4/11/08 documented sharp pain in the left shoulder with an onset date approximately seven weeks prior. The pain was described as ranging from "0" to "8" on a "0 - 10" pain scale and made worse by movement. Rest as well as aspirin or Tylenol were identified as providing relief. The initial occupational therapy (OT) assessment, dated 2/14/08, documented the patient as having no pain at the time of the visit. However, the patient reported left shoulder pain with active or passive range of motion. The occurrence of pain during a home visit was first documented on an OT progress note dated 2/29/08. The patient reported that aching left shoulder pain, rated as "5" on a "0 - 10" scale, had developed after the previous OT visit. Left shoulder pain was documented on subsequent OT visits dated 3/3/08, 3/5/08, 3/7/08, 3/10/08, 3/12/08, 3/26/08, 3/28/08, 3/31/08,	G 144		

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G 144	Continued From page 7 4/2/08, 4/7/08, 4/9/08, 4/16/08 4/18/08, 4/21/08, 4/23/08, 4/28/08, and 4/30/08. The pain was described as limiting the patient's progress. On the home visit dated 4/28/08 the pain was rated as "5" at rest and "8" with movement. The OT instructed the patient in use of a hot pack. On a progress note to the physician dated 4/24/08 the OT reported that heat and ice did not relieve the patient's left shoulder pain and requested suggestions for pain relief. A home visit with Staff 2, the HHA OT assigned to Patient #6, was made on 5/7/08 at 2:30 PM. The patient rated the left shoulder pain as "3." During the visit, the patient complained of sharp pain limiting any further exercise and pointed to the left deltoid area. Staff 2 inquired about the use of heat and suggested elevation. When interviewed by the surveyor, the patient's spouse stated that the patient did not like to take "pills" but would ask for Tylenol and that it helped. Following the visit Staff 2 was asked about Patient #6's use of Tylenol and replied that the patient did not like to take medications. He concurred that medication options for pain relief should have been discussed with the patient's physician and the HHA interdisciplinary team. Further review of the medical record revealed that Tylenol was not listed on either the original or recertification plans of care. The "Patient Medication Sheet" dated 2/13/08 also did not include Tylenol. The agency care conference book contained care conference notes for Patient #6 dated from 2/19/08 to 4/29/08. Only the note dated 4/15/08	G 144		

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G 144	Continued From page 8 documented the pain during OT sessions that the patient had been experiencing for approximately seven weeks. The patient's pain was not brought to the attention of the interdisciplinary team, including the physician, in a timely manner. The knowledge and skills of all therapeutic disciplines were not utilized in order to address medication and other options that may have reduced the pain and facilitated progress with therapy. The lack of documented interdisciplinary communication and collaboration in an attempt to reduce Patient #6's ongoing pain was discussed with the administrator on 5/8/08 at 12 PM.	G 144		
G 158	484.18 ACCEPTANCE OF PATIENTS, POC, MED SUPER Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. This STANDARD is not met as evidenced by: Based on observation, record review and interview, the agency failed to ensure that the interventions provided and the frequency of home visits made were consistent with the orders on the written plan of care (POC) established by the physician for 5 of 16 sample patients (Patients #1, 5, 6, 9, and 11) whose records were reviewed. Failure to follow the plan of care can result in identified patient needs being unmet. The agency also failed to ensure that the physician who established and reviewed the plan of care was licensed to practice in Idaho, as required by Idaho licensure requirements, for 1 of 1 sample patients with an attending physician located in another	G 158	First Choice Care Coordinator, Karen Nolt RN, and all other staff members have been appraised of the Idaho State Regulation that out of state referrals must have an In state physician prior to acceptance of out of state patients. Administrator reviewed and instructed First Choice Policy related to medication profile 3-002.1 and Medication Monitoring Policy 3-014.1 with all staff including PT, OT, SLP (see attached policy). Administrator educated staff to report new findings, change of patient condition to ALF, CG, and physician. They were also instructed to report all new/changed medications to ALF staff and physician prn. All staff will monitor the	5/20/2008 5/20/2008 5/20/2008

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G 158	Continued From page 9 state (Patient #8). Findings include: 1. INTERVENTIONS NOT CONSISTENT WITH ORDERS ON PLAN OF CARE: * Patient #9 was referred to the HHA on 4/14/08, after being discharged from the hospital. The patient was referred to the HHA for monitoring of "Medication compliance". The patient was admitted to the HHA's services on 4/15/08, with diagnoses which included pneumonia. The patient's POC stated that nursing staff was to monitor the patient's medication compliance. The patient was seen by the agency's nursing staff on 4/15, 4/17, 4/21 and 4/24/08. The patient's nursing notes did not document that the nurse had assessed the patient's medication compliance. On 5/08/08 at 5:58 PM, the Administrator reviewed the patient's record and confirmed the record did not contain documented evidence that the nurse had assessed the patient's medication compliance on her visits on 4/15, 4/17, 4/21 and 4/24/08. Nursing staff failed to follow the patient's plan of care and monitor the patient's medication compliance. * Patient #5 was admitted to the agency on 4/10/08 following hospitalization for an upper respiratory infection, bronchitis, and asthma exacerbation. The home health POC for the certification period 4/10/08 - 6/8/08 included skilled nursing assessment and reporting significant signs and symptoms related to vital signs, medication effects and compliance, and all other body systems, as well as instruction of the	G 158	above through First Choice quarterly QA projects. Outcomes will be reported to the administrator and report will be given at staff meeting.	

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G 158	Continued From page 10 patient and caregivers regarding disease process, new or changed medications, bowel care, and oxygen use/precautions. Review of skilled nursing home visit notes contained in the medical record showed that several new medications were identified during the comprehensive assessment (4/10/08). No patient or caregiver instruction was documented regarding the new medications. The patient's new medications included a nebulized bronchodilator combination. Neither the comprehensive assessment nor home visit notes dated 4/11/08, 4/14/08, 4/16/08, 4/18/08, 4/23/08, 4/25/08, 4/29/08, and 5/6/08 included documentation that the effectiveness of the nebulized medication had been assessed. The home visit note dated 4/14/08, documented that the patient's lungs sounded worse and that the patient had also experienced urinary retention, but there was no documentation of caregiver discussion or instruction regarding these new findings. The findings were not reported to the physician as required by the POC. The home visit noted dated 4/16/08 documented a non-injury fall and an increase in lower extremity edema, but there was no documentation of communication with either the caregivers or the physician. The home visit note dated 4/25/08 documented the presence of wheezes and crackles as well as increased lower extremity edema, but there was no documentation of caregiver discussion or instruction regarding these findings. Although the patient's oxygen dose was changed	G 158		

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G 158	Continued From page 11 by the physician on 5/2/08, the 5/6/08 home visit note contained no documentation that the changed order had been discussed with caregivers. As of a home visit observation on 5/7/08 at 10:15 AM, the patient was not receiving the prescribed oxygen at night. Changed medications were also noted at the home visit dated 5/6/08, but no patient or caregiver instruction was documented regarding these new medications. The failure to follow the written POC was discussed with the administrator 5/8/08 at 1:15 PM. 2. MISSED OR EXTRA VISITS: * Patient #11 was admitted to the HHA's services on 3/24/08, with diagnoses which included an open wound on knee. The patient's physician had ordered physical therapy 2 times a week for 6 weeks. The record contained "Missed Visit" forms, dated 3/31 and 4/16/08, that documented the Physical Therapist had missed the scheduled home visits. The forms did not include documented evidence the Therapist had notified the physician of the missed visits. Further, on the week of 4/20/08, the physician had increased the skilled nursing visits to 5 times a week for 1 week. Nursing staff had documented that they saw the patient that week on 4/22, 4/23, 4/24, and 4/25/08. There was no documented evidence of a 5th visit that week, nor was there documented evidence that the physician had been notified of the missed visit. On 5/08/08 at 5:36 PM, the Administrator stated Physical Therapy and Nursing staff were to notify physicians of missed visits. She confirmed the	G 158	Missed visit form was developed after our survey and now in use by all staff. Medical record and chart audit personell, Colleen, will monitor on an ongoing basis to be assured these have been faxed to the patients MD	5/12/2008

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G 158	Continued From page 12 "Missed Visit" form, that was filled out by the Physical Therapist, did not contain documentation that the physician had been notified of the missed visits. Further, she confirmed the the nurse did not document that she had also notified the physician about her missed visit on the week of 4/20/08. The HHA failed to ensure that visits were provided as ordered by the physician and that the physician was notified of missed visits. * Patient #1 was admitted to the HHA's services on 10/30/07, with diagnoses which included diabetes. The patient's physician had ordered skilled nursing visits, 1 time per week, for 8 weeks. On the weeks of Jan 6 through the 12th and the week of 13th through the 19th of 2008, there was no documented evidence that the nurse made a home visits per physician order. In fact the patient had not been seen at all during that 2 week span. Further, on the week of February 10-16 of 2008, there was no documented evidence that the nurse made a home visit per physician order. On 5/8/07 at 3:00 PM, the administrator confirmed the record did not contain documented evidence that the nurse had notified the physician of the missed visits. The HHA failed to ensure that visits were provided as ordered by the physician and that the physician was notified of missed visits. * Patient #6 was admitted to the agency on 2/13/08, with diagnoses including hemiplegia (paralysis of one side) following a stroke. During	G 158		

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	137108	A. BUILDING _____ B. WING _____	05/09/2008

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G 158	Continued From page 13 the original certification period of 2/13/08 - 4/12/08 the following disciplines provided care: physical therapy, occupational therapy, home health aide, and medical social work. The medical record included missed visit forms dated 2/26/08 for the medical social worker and the home health aide. The record contained additional home health aide missed visit forms for 3/21/08, 4/8/08, and 4/11/08. The medical record did not contain evidence that the physician had been notified of these missed visits. The missed visits were brought to the attention of the administrator on 5/9/08 at 9 AM, who confirmed that the physician had not been notified. 3. PHYSICIAN NOT LICENSED IN STATE OF IDAHO: * Patient #8 was admitted to the agency on 4/25/08 primarily for skilled nursing assessment and caregiver instruction related to a central venous catheter and TPN (total parenteral nutrition). The plan of care for the certification period 4/25/08 - 6/23/08 listed a physician with a mailing address in California. No Idaho physician was listed. According to the definitions contained in the federal regulations for home health care at 42 CFR 484.4, a physician is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine and surgery by the State in which such function or action is performed. Because the attending physician was not licensed to practice in the state of Idaho, he did not meet the regulatory definition of physician.	G 158		
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the	G 176		

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G 176	Continued From page 14 physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by: Based on home visit observation, clinical record review, agency policies, and staff interview the agency failed to ensure complete documentation of assessment findings, patient/caregiver instruction, and communication regarding assessed changes in medical status for 2 of 4 patients residing in an Assisted Living Facility (Patients #5 and 1). Patients were at risk for delayed treatment or slower recovery from acute illness as a result of incomplete assessment documentation, patient instruction, and communication with Assisted Living Facility staff. Findings include: * The HHA's "CARE COORDINATION" policy, dated January 2004, stated "The clinicians will be responsible for facilitating communications about changes in the patient's status among the assigned personnel... written evidence of care coordination will be recorded during the case conference and repeated in skilled nursing visit reports in the patient's clinical records....Organization personnel will communicate changes in a timely manner via telephone, one-to-one meetings, case conferences and home visits. Documentation of all communications will be included in the clinical record on a communication note, case conference summary, or clinical note. Documentation will include: the date and time of the communication, individuals involved with the communication, information discussed, and the outcome of the communication...Written evidence of care coordination may be found in the plan of	G 176		

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G 176	Continued From page 15 care, case conference summary forms, or clinical notes in the patient's clinical record." The agency's policy did not include how the agency was to coordinate care with a patient living in an assisted living facility, with access to skilled nursing and other unlicensed staff involved in the day-to-day care of the patient. * Patient #5, age 89, was admitted to the agency on 4/10/08 following hospitalization for an upper respiratory infection, bronchitis, and asthma exacerbation. The patient, who also had a history of congestive heart failure, resided in an Assisted Living Facility. Medications were administered by a medication aide, and a registered nurse (RN) provided overall health management for all patients residing in the facility. During an interview on 5/7/08 at 10:05 AM, the assisted living RN stated that she was responsible for monthly assessments of all patients but would do additional assessment on an as-needed basis. As an example she described that a two-pound weight gain had recently been reported for Patient #5, and she had responded by checking the patient for peripheral edema and listening to the lungs. Patient #5's admission comprehensive assessment, dated 4/10/08, contained a section for documenting cardiopulmonary findings. The category entitled, "Breath Sounds," noted the presence of rhonchi, which are secretions within larger airways. Although rhonchi can often be coughed out and the patient was described as having a productive cough, there was no description of the color or consistency of sputum produced. Review of the medication sheet revealed several new medications: Advair, a long-acting bronchodilator and corticosteroid	G 176		

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G 176	Continued From page 16 combination administered as a dry powder inhaler; DuoNeb, a combination of two short-acting bronchodilators administered by nebulizer; Ceftin, an antibiotic used to treat bacterial infections; and tapering doses of prednisone. Patient #5 was also to receive continuous oxygen at 2 LPM (Liters/Minute) to keep the oxygen saturation value at or above 90%. The comprehensive assessment documented the patient's oxygen saturation value on room air but did not indicate whether the value was obtained at rest or during activity. Skilled nursing interventions during the comprehensive assessment visit revealed no documentation of patient instruction or coordination with Assisted Living Facility staff regarding the use of the new medications or oxygen. A skilled nursing home visit note, dated 4/14/08, documented lung sounds as abnormal, with expiratory rhonchi throughout, and a comment that the patient's lungs sounded worse. The section to document cough and sputum was blank. According to the medication sheet, the prednisone dose had been decreased from 60 mg./day at admission to 20 mg./day on the date of the home visit; however, there was no documentation regarding the response of the patient to the prednisone taper. The patient's weight was recorded as decreased by four pounds from the admission weight and there was narrative documentation questioning whether daily weights were being done. A box indicating retention was checked under the genitourinary section of the note, with the narrative added, "Difficulty starting." Despite these changed assessment findings and question regarding daily weights, the sections of the home visit note regarding changes in the care plan and	G 176		

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G 176	Continued From page 17 coordination of services were both blank. The next skilled nursing home visit note was dated 4/16/08 and documented that the patient had experienced a non-injury fall the previous night. The patient's lower extremity edema was recorded as "+2," an increase from the "1+" value recorded at the 4/11/08 visit. However, the patient's weight was not recorded. There was no documentation of communication about the fall or the possible significance of the increased edema, for a patient with a history of congestive heart failure, with Assisted Living Facility staff. The next skilled nursing home visit note, dated 4/18/08, documented an episode of urinary incontinence and a four pound weight loss in nine days. There was no documentation that these findings had been discussed with the assisted living RN. The patient's oxygen saturation value was documented on room air, but there was no indication of the patient's activity at the time the value was obtained. The medical record included a fax note to the physician, dated 4/18/08, indicating that room air saturation values had been greater than 90% at all home visits and requesting that oxygen be discontinued. There was no documentation that the effect of walking or activities of daily living on the patient's oxygen level had been evaluated prior to this request. The physician responded with an order to discontinue oxygen during the day but to test the saturation level at night. The subsequent skilled nursing home visit, dated 4/23/08, documented that the patient had been started on an antibiotic for a urinary tract infection.	G 176		

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G 176	Continued From page 18 The next skilled nursing home visit note, dated 4/25/08, documented an expiratory wheeze and more pronounced crackles. The patient's peripheral edema had increased from "trace" ankle swelling at the previous home visit to "+2" in both lower extremities at this visit. Again there was no documentation that the possible significance of these findings had been discussed with the assisted living RN and a collaborative decision made whether to continue assessment of the patient or contact the physician to revise the plan of care. The skilled nursing home visit note dated 4/29/08 documented a weight increase of five pounds in eight days and a further increase in lower extremity edema. The medical record included a fax note to the physician, dated 4/29/08, that reported the increase in the patient's weight and edema. Review of the attached weight record revealed that the patient's weight had ranged from a high of 166 pounds, the day prior to admission to the HHA, to a low of 157.2, on 4/21/08. Day-to-day fluctuations between 4/21 and 4/29/08 had varied from 0.2 to 2.8 pounds, with a 1 pound loss between 4/28/08 and 4/29/08. There was no documentation that the need for consistency in the time of day, clothing worn, food or beverages consumed, and the need for an empty bladder had been discussed with assisted living staff. Without assuring consistency in these factors, treatment decisions can be based on inaccurate information. The fax to the physician, dated 4/29/08, also requested a reduction in the frequency of nebulizer use. There was no documentation that the effectiveness of the nebulizer had been specifically evaluated for Patient #5 or that the	G 176		

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G 176	Continued From page 19 possible need for alternative short-acting bronchodilators, such as those administered by metered dose inhaler, had been discussed with the patient or with facility staff. Two days later (5/1/08) a home visit note by the Physical Therapy Assistant (PTA) documented that the patient was wheezing during seated exercises. The PTA reported that the patient probably needed four nebulizer treatments during the day but was refusing two of them, and that she had communicated this information to the home health agency nurse. Further review of the medical record revealed a nocturnal pulse oximetry report dated 4/25/08 and received by the HHA on 4/29/08. The test was performed on room air and indicated that the patient had oxygen saturation values at or below 88% for much of the night. The value of 88% is often a threshold value for providing oxygen therapy, and the summary comment indicated that nocturnal oxygen therapy should be considered. The medical record also included an "MD Visit Communication Sheet" for a physician visit dated 5/2/08, as well as a laboratory report dated 5/2/08. The top portion of the "MD Visit Communication Sheet" included a narrative note, apparently written by Assisted Living Facility staff, indicating that the resident wanted to decrease nebulizer use but continued to wheeze. The lower portion of the note contained physician including a new antidepressant, a change in the medication used to treat gastric reflux, a change in cardiac medications, and orders for oxygen 2 LPM at night. A separate physician entry on the laboratory report showing a low-normal serum	G 176		

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G 176	Continued From page 20 potassium value contained an order for a potassium-sparing diuretic. The most recent skilled nursing home visit note, dated 5/6/08, was four days after the patient had been seen by the physician. This note documented continued peripheral edema, crackles heard on auscultation of lung bases, and a weight of 165 pounds. This weight was 3 pounds higher than on the date of the previous home visit and was higher than any weights recorded after 4/16/08 on the log faxed to the physician. The weight was evaluated as decreased by 2.4 pounds, although the narrative did not indicate on what date the patient's weight had increased. The narrative documentation concluded that the patient had "fluid overload" and indicated that the physician had increased the patient's diuretic. Patient instruction was documented regarding use of oxygen at night and use of the nebulizer only as necessary. There was no indication that nebulizer or alternative bronchodilator use had been further evaluated or of patient instruction regarding possible side effects of the new medications. Similarly, there was no documentation of discussion with assisted living staff regarding the continued edema, weight status, nebulizer or other bronchodilator use, the medication changes, and the new order for oxygen at night. A home visit with the PTA was made to Patient #5 on 5/7/08 at 10:15 AM. The patient's living room contained an oxygen concentrator, which was turned off. No oxygen equipment was visible in the patient's bedroom, and the patient stated that staff had not yet provided oxygen at night. When asked by the PTA if still using the nebulizer, the patient replied, "No, they told me they were	G 176		

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G 176	Continued From page 21 ceasing." A metered dose inhaler, containing albuterol, a short-acting bronchodilator, was noticed on the patient's bedside table. The patient stated that the cannister was empty and s/he had asked the medication aide about getting a new one because it was helpful when short of breath. Communication with assisted living staff regarding changes in patient status and the incomplete documentation found in home visit notes was discussed with Patient #5's home health agency case manager, Staff 1, on 5/8/08 at 2:30 PM. She stated that she "touched base" with staff and left a copy of the home visit note with facility staff but acknowledged that communication with Assisted Living Facility staff had not been documented. She stated that although she had talked with staff to make sure the patient was being weighed, she had not discussed the need for consistency in clothing worn and other factors that could influence the weight result. She also stated that she had not checked the patient's oxygen saturation values during walking or other activities of daily living because she expected physical therapy to do this. On 5/8/08 at 1:15 PM the administrator stated that instruction regarding new medications, such as those delivered by nebulizer, should be a collaborative process shared by assisted living and home health agency staff. Home health clinicians were expected to monitor oxygen use and check oxygen saturation values both at rest and during activity. She concurred that the documentation for Patient #5 was insufficient. During a follow-up phone call on 5/9/08 at 1 PM the administrator stated that physical therapy had not evaluated Patient #5's oxygen saturation	G 176		

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G 176	Continued From page 22 values because it had not been identified as part of the physical therapy regimen for this patient. * Patient #1 was admitted to the HHA's services on 10/30/07, with diagnoses which included diabetes. The patient resided in an Assisted Living Facility. The Assisted Living Facility employed a registered nurse who was responsible for the health management of the patient. The patient's POC, dated 10/30/07, stated that skilled nursing was to instruct the client and the caregiver in the management of the patient's diabetic care. On May 15, 2008 at 11:50 AM, the Program Manager of the American Diabetes Association in Portland, stated that a normal blood glucose level is anywhere between 80 and 140mg/Dl, in the elderly. The patient's record contained a fax sent to the physician by the HHA nurse dated 11/1/07, documenting the patient's abnormal blood sugar results were as follows: 11/1/07-AM 173 Eve 195 HS (night-time)275 11/2/07 AM 163 Eve 175 HS 210 11/3/07 AM 171 HS 283 11/4/07 AM 219 Eve 230 HS 185 11/5/07 Eve 276	G 176		

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G 176	Continued From page 23 HS 414 11/6 /07AM 193 Eve 188 HS 326 11/7/07 AM 177 Eve 357 HS 441 11/8/07 AM 145 Eve 237 HS 322 11/9/07 Eve 510 HS 333 11/10/07 Eve 305 HS 184 11/11/07 Eve 260 HS 288 In an interview with the administrator which occurred at 1:30 PM on 5/8/08, the administrator verified that there was no documentation to support the necessary coordination of services within the HHA and the Assisted Living Facility, as was required by the RN. No documented evidence in the patient's record that the nurse had communicated the patient's blood glucose variances with the Assisted Living Facility was available. The patient's POC, dated 12/30/07, did not state how the HHA was going to coordinate the patient's diabetic care with the Assisted Living. The patient's record contained a fax dated 1/29/07, from the HHA to the patient's physician, that documented the patient's abnormal blood sugar results are as follows: 1/15 Eve 360 HS 535	G 176		

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G 176	Continued From page 24 1/16 AM 239 Eve 285 HS 309 1/17 AM 258 Eve 310 1/18 AM 177 Eve 477 HS 438 1/19 AM 334 Eve 195 HS 455 1/20 AM 234 Eve 333 HS 335 1/21 AM 163 Eve 284 HS 393 1/22 AM 327 Eve 273 HS 366 1/23 AM 152 Eve 181 HS 284 1/24 AM 166 Eve 308 HS 450 1/25 AM 167 Eve 331 HS 300 1/26 AM 277 Eve 403 HS 510 1/27 AM 297 HS 247 There was no documented evidence in the patient's record that the nurse had communicated the patient's blood glucose variances with the Assisted Living Facility.	G 176		

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G 176	Continued From page 25 A Skilled Nursing Visit Note written on 2/1/08 stated "BG's elevated". A Skilled Nursing Visit Note written on 2/5/08 stated "BG's since 2/1/08 low 300's except one in the 400's. " A Skilled Nursing Visit Note written on 2/12/08 stated that "Insulin changed by MD yesterday." Patient #1 went from 12/27/07 until 2/11/08 without any change in insulin orders to help with her diabetic condition. There was no documented evidence in the patient's record that the nurse had communicated the patient's blood glucose variances with the Assisted Living Facility. Further, there was no documented evidence in the patient's record that the nurse had communicated the patient's insulin change on 2/12/08. Patient #1 went for 46 days without the updated insulin orders. In an interview with the administrator which occurred at 1:30 PM on 5/8/08, the administrator verified that there was no documentation to support the necessary coordination of services within the HHA and the Assisted Living. No documented evidence in the patient's record that the nurse had communicated the patient's blood glucose variances with the Assisted Living Facility was available. The registered nurse failed to coordinate services with the Assisted Living Facility with the patient's change in condition and needs.	G 176		
G 337	484.55(c) DRUG REGIMEN REVIEW The comprehensive assessment must include a	G 337		

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G 337	Continued From page 26 review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. This STANDARD is not met as evidenced by: Based on record review and staff interview it was determined that the agency failed to ensure that patient's medications were reviewed to identify any potential medication complications for 1 of 16 sampled patients (#13) whose records were reviewed. This lack of an accurate medication review could lead to potential harm to the patient in the form of drug reactions or adverse medication interactions. Findings include: 1. Patient #13 was an 84 year old female admitted to HHA services on 4/26/08. Admitting diagnoses included fractured sacrum/pelvis and Irritable Bowel Syndrome. She was a resident at an Assisted Living Facility. Physical Therapy was the only discipline providing care. The list of current medications used for the comprehensive assessment, and subsequently the POC for the patient, consisted of a Medication Disbursement record from the ALF. This list, compiled at the time of the comprehensive assessment on 4/26/08, was not consistent with the Medication Profile Report sent from the rehabilitation hospital at the time of the patient's discharge. The discrepancy between these two lists led to incorrect medications being placed on the patient's POC that was sent to the physician, by the HHA, for signature. Discrepancies include: a. The medication Klonopin was included on the	G 337	Administrator reviewed and instructed Medication Regimen with all professional staff. Policy Medication Profile 3-002.1 and Medication Monitoring 3-014.1 were included in review. Cathy Jerrems RN reviews all therapy only cases. This citation will be reviewed by quarterly reviews by RN, PT, OT, SLP which will be turned in to the administrator for final review. All staff will will be informed of any deficiencies.	5/20/2008

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	137108	A. BUILDING _____ B. WING _____	05/09/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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G 337	Continued From page 27 discharge list but not on the ALF list or the POC. It was added as a new medication on the HHA medication list on 5/5/08. b. The medication Norco was included on the discharge list but not on the ALF list or the POC. It was added as a new medication on the HHA medication list on 5/5/08. c. The medication Librax was included on the discharge list, the ALF list and the POC. It was also added as a new medication on the HHA medication list on 5/5/08. d. The medication Tylenol was include on the discharge list, the ALF list and the POC. It was also added as a new medication to the HHA medication list on 5/5/08. On 5/8/08 at 1:30 PM the agency administrator confirmed that the medication list was not complete. Lack of an accurate current medication list could lead to potential harm to the patient in the form of drug reaction or interaction.	G 337		

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N 000	16.03.07 INITIAL COMMENTS The following deficiencies were cited during the recertification survey of your agency. The surveyors conducting the recertification survey were: Patrick Hendrickson, RN, HFS, Team Leader Sharon Mauzy, RN, HFS Patricia O'Hara, RN, HFS Joanne Rokosky, RN, CMS Acronyms used in this report: BG's = Blood Sugars HHA = Home Health Agency MG = Milligrams MSW = Medical Social Worker POC = Plan of Care RN = Registered Nurse SOC = Start of Care	N 000	RECEIVED JUN 04 2008 FACILITY STANDARDS	
N 062	03.07021. ADMINISTRATOR N062 03. Responsibilities. The administrator, or his designee, shall assume responsibility for: i. Insuring that the clinical record and minutes of case conferences establish that effective interchange, reporting, and coordination of patient care between all agency personnel caring for that patient does occur. This Rule is not met as evidenced by: Refer to G144 as it relates to the agency's failure to ensure that patients' clinical record and case conferences, for patients' residing in an Assisted Living Facility, documented an effective interchange, reporting, and coordination of patient	N 062	Refer to G144	

Bureau of Facility Standards

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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N 062	Continued From page 1 care had occured. Findings include:	N 062		
N 097	03.07024. SK. NSG. SERV. N097 01.Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the following: e. Prepares clinical and progress notes, and summaries of care; This Rule is not met as evidenced by: Refer to Federal deficiency G 176, as it relates to the failure of the agency to ensure complete documentation of assessment findings, patient/caregiver instruction, and communication regarding assessed changes in medical status for patients residing in an Assisted Living Facility. Patients were at risk for delayed treatment or slower recovery from acute illness as a result of incomplete assessment documentation, patient instruction, and communication with Assisted Living Facility staff.	N 097	Refer to G176	
N 152	03.07030.01.PLAN OF CARE N152 01. Written Plan of Care. A written plan of care shall be developed and implemented for each patient by all disciplines providing services for that patient. Care follows the written plan of care and includes: This Rule is not met as evidenced by:	N 152	Refer tp G 158	

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N 152	Continued From page 2 Refer to G158 as it relates to the failure of the agency to ensure that interventions provided and the frequency of home visits made were consistent with the orders on the written POC established by the physician. The agency also failed to ensure that the physician who established and reviewed the plan of care was licensed to practice in Idaho, as required by Idaho licensure requirements.	N 152		
N 173	03.07030.07.PLAN OF CARE N173 07. Drugs and Treatments. Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to Federal deficiency G 337, as it relates to the failure of the agency to ensure medications were reviewed to identify any potential adverse effects, drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, or noncompliance with drug therapy.	N 173	Refer to G 337	